Murrumbidgee Primary Mental Health Stepped Care Model Co-Design Project

Key literature summary – February 2019

Centre for Rural & Remote Mental Health

Prepared by

Dr Scott Fitzpatrick, Mr John Leary, Dr Hazel Dalton and Professor David Perkins

About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the Integrated Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

Centre for Rural & Remote Mental Health

ramhp RURAL ADVERSITY MENTAL HEALTH PROGRAM

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Proudly funded by NSW GOVERNMENT

Contents

1 Background

1.1 Principles of stepped care

Stepped care can be understood as a staged system for the delivery of adaptive treatment in which treatment options are organised in a hierarchy of intensity that correlates with the acuity and complexity of conditions [1, 2]. Stepped care comprises two key principles:

i) The principle of 'least burden' where less intensive and restrictive treatment options that still provide significant health gain are recommended to patients first [3, 4].

ii) The principle of 'self-correction' where treatment strategies are responsive to patient progress, and corrections to the level of care are made based on regular assessment [5, 6].

As a system for the allocation of treatment, stepped care documentation has little to say about care quality beyond the provision of evidence-based treatments. Stepped care is compatible with other approaches that aim to improve care quality such as collaborative care and person-centred care (Hill 2016). System requirements regarding the efficient use of resources, therefore, must be balanced against patient choice, service integration, and the need for multidisciplinary team-based care to optimise outcomes [7, 8].

1.2 A hierarchy of treatments

There is an implicit assumption in the language of stepped care that high intensity treatment is in some way superior to low intensity treatment, and that low intensity interventions are unsuitable for patients with more severe symptoms [2, 9]. Terms such as 'stepping up' and 'stepping down' assume a hierarchy; suggesting that some treatments are 'better' than others. This can be an unhelpful way of viewing things, and can lead to health professionals and patients viewing the level and quality of care provided by low intensity services as inappropriate.

It is important to note that high intensity treatments are not necessarily more effective than low intensity treatments [2]. For example, there is little evidence that individual therapy is more effective than group therapy, or that computerised cognitive behavioural therapy (CCBT) is more effective than supported book-based self-help [2, 9]. With regards to depression, a recent meta-analysis of patient data in primary care and community settings showed that patients with more severe symptoms of depression showed as much clinical benefit from low intensity interventions as those with less severe symptoms [10].

Treatment guidelines that recommend stratified stepped care for depression may reinforce the view that low intensity interventions are unsuitable for some patients [2]. It may be more helpful, therefore, to conceptualise stepped care within the context of

an ethical imperative of choosing the most beneficial and least intrusive intervention taking into account principles of 'matched care' [1]. 'Matched care' seeks to offer patients a choice regarding the type of intervention and type of support needed. It incorporates a process of informed consent about treatment options, as well as assessment of diagnosis and learning styles in order to avoid assumptions about the superiority of some treatments in stepped care models [1, 9].

2 Models of stepped care

2.1 Stepped or stratified models

Review finding: The roll out of the model in 2016/2017 appears to have been done with inadequate information to service providers and referrers, resulting in confusion about how it works, who the providers are and their role, and what the support systems should be doing.

Despite stepped care frameworks increasingly being recommended as a way of structuring clinical pathways to care, there is no formal blueprint for the organisation and delivery of services within this model [4]. Rather, in recognition of the ways in which local factors shape and constrain action, there is an explicit emphasis on the development of local care pathways involving primary and secondary care clinicians, managers, commissioners and service users [6, 11].

Although there exists some variability in the design and implementation of stepped care models, a number of key principles are associated with positive outcomes. These focus on the provision of information, patient involvement, and clarity about pathways through care and the processes by which this is assessed [11]. Evidence indicates that an effective stepped care model of service delivery is one that:

- is responsive to the needs of people with common mental health issues (including cultural, gender, and age appropriate services) their families, carers and professionals;
- adapts the model to fit around the patient and not the patient around the model;
- minimises the need for transition between different services or providers;
- is integrated and provides easy movement between different levels of the pathway and to other pathways (e.g. physical health);
- offers prompt and the minimal number of assessments to access interventions;
- has designated staff who are responsible for the co-ordination of people's engagement with the pathway;
- does not use single criteria such as symptom severity to determine movement between steps;

- is outcomes focused, and has clear criteria for determining access to, and movement between, the different levels of a pathway, including mechanisms for responding promptly to changes in patient needs;
- shares and communicates information with patients and with GPs and other health professionals; and
- provides training and support on the operation of the pathway [11].

Stepped care interventions can be delivered using 'stepped' or 'stratified' models of care. Both models incorporate low and high intensity treatments, yet the way patients are allocated to different intensities differs [4]. In a stepped model, almost all patients start with low intensity treatment initially, stepping up to more intensive treatment if required. In contrast, a stratified model seeks to match interventions to patients based on their presenting characteristics [2, 4]. That is, some patients begin with low intensity treatment while others are directly assigned to high intensity treatment. In this form of stepped care, some clinical judgment has to be made regarding the presenting characteristics of individual patients, levels of risk, and the likely response of patients to the interventions available [6].

2.2 Characteristics of stepped care models

Review finding: The relative proportions of service type and intensity in the current service provider contracts were determined prior to the recent work based on the National Mental Health Services Planning Framework. The proportionate size and mix of the services within the intensity levels has not been determined with any accuracy yet.

In most high income countries, the provision of stepped care involves the availability of a range of low and high intensity interventions, provided either by the GP, or in collaboration with other primary or secondary mental health care professionals. While guided self-help is commonplace in UK stepped care services, Dutch studies found the provision of low intensity self-help interventions limited in general practice [4, 12].

Recent reviews of stepped care models identified the following health care professionals as involved in the delivery of care: general practitioners, nurses, psychiatrists, social workers, psychologists; as well as less qualified staff: residential home staff, an assistant patient navigator, and a lay health counsellor [2, 4]. The reviews identified a range of steps in study trials. These include:

- Watchful waiting – this refers to a process of active monitoring in cases of mild common mental health problems (for e.g. caused by situational stressors) that may disappear without specific intervention and where immediate treatment may be iatrogenic. It involves discussing the presenting problem, the nature and course of the problem, and a further assessment or follow-up, normally within two weeks [1, 2, 11]. This step poses challenges for patients who may

have delayed accessing professional support and are directed toward a watchful waiting step [13].

- Bibliotherapy – the most widely used form of bibliotherapy is self-help books based on CBT which offers an effective and accessible form of mental health care for a range of conditions including depression, anxiety, chronic fatigue syndrome, eating disorders, and obsessive compulsive disorder [14]. Health professional support and guidance increases the effectiveness of self-help, as does the quality of resources [15, 16]. The demanding nature of some resources mean that not all patients will engage and benefit from self-help bibliotherapy. Those who are literate, highly motivated, and able to work on their own in a structured and practical manner are most suited to this form of treatment [17, 18].
- E-Health – this comprises a range of interventions that use technology to provide general or tailored interactive modules. This includes computer-based interventions that involve little or no practitioner contact, and computer-assisted interventions that involve clinical supervision across low and high intensity interventions [1]. Like self-help bibliotherapy, it is more effective with practitioner support and guidance [9].
- Group therapy – this form of therapy can vary greatly in where it fits in the stepped care model depending on the structure and purpose of the group [1]. For example, it can be used to support individual recovery and improve the quality of life of people using mental health services through group support activities such as Recovery Colleges, art therapy, support groups, and so forth. It can also be delivered in the form of group therapy for specific conditions such as alcohol and substance dependence, sexual assault, post-traumatic stress disorder, and psychosis.
- Individual therapy – this generally refers to both short term or more complex and specialised face-to-face psychological interventions delivered by trained paraprofessionals, mental health practitioners or practice-based counsellors. This is the most common first step though it is often overused and does not necessarily lead to the best outcomes [1].
- Medication – one of the most utilised interventions in primary care settings despite issues related to the safety and efficacy of this treatment option. May be viewed as a lower step in terms of time, access and effort but a higher step in terms of adverse side-effects and higher long term costs [1].

- Crisis teams and in-patient treatment – for severe and complex conditions often involving issues of suicide and self-harm provided by specialist clinical teams. The highest step in treatment.

Review finding: Some communities in MPHN that do not have enough therapists based locally have limited options or long distances to travel and waiting times. The design of the stepped care system needs to engage with this common challenge and develop transparent responses that the community and health professionals can understand and work within.

In low resource settings, where the availability of interventions is limited due to health infrastructure, funding and/or workforce shortages, internal stepped care models based on a common elements approach have been proposed as a more efficient, scalable and sustainable solution [19]. A common elements approach is based on the understanding that most evidence based treatments comprise many similar practice elements or strategies that the same service provider can match to patients based on their problem, as well as taking into account specific demographic and contextual factors [19, 20].

Practice elements are typically drawn from evidence-based protocols, ideally with professional consultation, which are grouped into *practice element profiles* to form a set of treatment interventions for treating a range of presenting problems [19, 20]. Practice elements typically include clinical techniques such as cognitive/coping, problem solving, skill building, social skills training, relaxation and psychoeducation [20]. Having trained in a common elements approach, one service provider is then able to utilise individual elements, adding elements and/or dose of elements as required, to address a range of problems and severities [19].

2.3 Intake/assessment/referral

It is well known that initial contact with a health care provider is a significant barrier to treatment, and that people with mental health problems often delay accessing support [5, 13]. Those who receive an assessment and referral may also not receive timely treatment due to long wait times. This is complicated further by a recognition that those who do not receive their preferred treatment option do not seek treatment [1]. In a review of four stepped care services in the UK, the attrition rates between referral and assessment and between assessment and treatment were around 25% to 33% [4].

Methods of intake and assessment of patients can be divided according to the chosen system and whether a stratified or stepped model is in place. There is considerable debate around the assessment process, the use of screening tools that can be used with or without a qualified mental health professional, and whether they should be conducted by telephone or face-to-face.

Optimal care includes clinical assessment to determine the severity and duration of symptoms. Evidence indicates this can be done reliably through less invasive and costly methods such as telephone, video-conferencing and online assessments [1, 12]. It is worth noting, however, that comorbidities are the rule rather than the exception, and that assessment models must be able to cope with comorbidity in order to better guide treatment options [13]. A focus on single disorders or criteria (such as symptom severity) may result in the exclusion of people with more complex needs [7, 13].

Review finding: There's a concern raised that risk is being over-estimated by the Central Intake Team, leading to consumers receiving a higher level of care than necessary or as advised by the GP. This has resulted in consumers receiving less than timely and appropriate treatment following referral by the GP.

Transdiagnostic staging models that provide mental health assessments across multiple domains (mental health and clinical stage; education, training and employment status; risk of injury, self-harm and suicide; use of alcohol and other drugs; quality of physical health; and quality of family and social relationships) have been put forward as a way of responding to these complexities and matching intervention intensity to the level of need [13].

Such an approach recognises that parallel interventions may be required for co-existing risk factors, and that in some cases care is already being provided by general practitioners and/or other health and social services. Assessment and shared treatment planning that allows for more subjective clinical judgement, as well as negotiation over the allocation of tasks and responsibilities, is necessary in these cases to ensure optimal care [7, 12].

Review finding: Direct referrals by GPs (by-passing central intake) sometimes occur to avoid waiting times or because the service provider is located in the GP practice. The latter points to the need for flexible processes to support alternative referral pathways where these make sense.

Access to stepped care systems varies. In some models, a central intake system staffed by qualified health professionals (nurses and social workers) assesses and allocates patients to different steps. In other models, patients are assessed and allocated by both low and high intensity clinicians [6]. There is some variance regarding GPs and others capacity to refer directly to stepped care services. Some models require referrals to go through a single entry point, while others allow professionals to refer to different steps based on their clinical assessment [4]. There is also some variance regarding self-referrals. Some models require all referrals to go through a GP; others allow unrestricted self-referral, while others allow self-referral to low intensity services only [6].

Research indicates that stepped care systems are extremely sensitive to on the ground decision-making where local factors play a pivotal role in assessment and referral processes that impact patient pathways [6]. Workforce shortages, long wait times, transport and mobility issues, costs to service users, relationships between different professional groups, patient preferences and previous experiences with mental health care play an important role in determining treatment allocation [6, 7, 12]. For example, in areas where low intensity services are scarce or viewed with apprehension by patients and/or health professionals, referral to medium or high intensity services may result. Similarly, a shortage of high intensity services may result in patients receiving low intensity services [6].

Review finding: The guidance documentation available to the central intake team is insufficient for them to do their job properly. There is a need for more detailed clinical procedures, and there are reported discrepancies in knowledge about services, eligibility criteria and stepped care.

While commencing treatment with low intensity interventions such as self-help may reduce the burden on services, it may also be burdensome for patients to receive low-intensity treatment, particularly as a stop gap measure only [1, 6]. There is also a risk that patients who do not respond to low-intensity interventions may develop negative attitudes and disengage from further treatment [2, 7].

The importance of a health care service that supports patient choice is a feature of Department of Health stepped care guidance [21]. Allowing patients to choose between treatment options may be less cost-effective if most patients choose high intensity services (Hill 2016). However, systems and practices that are designed to inform patients about treatment options and the advantages and disadvantages of each (including evidence, costs and outcomes) so that they can explore options and participate in shared treatment planning has met with positive results [1]. Addressing health literacy skills including language barriers and cultural issues will further help patients to make informed decisions [1].

Review finding: The central intake staff are very consumer-centred and carry out their roles with enthusiasm and commitment, but the role of central intake is not well-understood by referrers and service providers. There are too many assessment points in the current model. Consumers are having to tell their stories at three steps in the process: to the GP; to the central intake team; and to the service provider.

It is important to note that the level of care required must also be determined by regular monitoring, and that referral through a central intake system cannot replace this important clinical responsibility of the service provider.

2.4 Care pathways in stepped care models

Lack of diversity in the types of treatment offered to patients who may not be benefitting from current treatment may also lead to patient dissatisfaction and disengagement from services [7]. For example, if people do not respond adequately to self-help treatment (for example, CCBT), then face-to-face treatment based on the same therapeutic modality may also offer no benefit, even if offered at a higher step in the model [7, 22]. Hence, there should be adequate resources in all steps of the system to offer variation in treatment modalities.

> Review finding: Where psychological therapy is indicated, a lower and medium intensity option for some cases might be shorter (half-hour) sessions. This option does not appear to have been taken up as much as expected.

Variation in the intensity of treatment is also a key element of stepped care models and should be responsive to patient need and progress [5, 6]. Rigid application of systems that limit session numbers and prevent practitioners from flexibly adjusting a course of treatment to meet patient needs may be disadvantageous, particularly if a patient is showing signs of progress and would continue to benefit from more treatment at a lower intensity [6].

Stepped care models should be self-correcting, and this includes a provision for varying treatment intensity at the same step based on greater contact time between practitioner and patient; or conversely, lesser contact should significant health gains be made [5, 6].

2.5 Monitoring

> Review finding: More robust monitoring of central intake and service provider activity and outcomes is required. The role of central intake could be developed to drive change through specified projects in the development of the stepped care system and clinical outcomes. This would necessarily involve open lines of communication between central intake and service providers.

A key feature of stepped care models is the proactive monitoring of treatment outcomes to assist practitioners and patients to determine intervention intensity and whether a patient should step up or down [13]. Criteria and processes for monitoring patient progress and for facilitating step-up or step-down, therefore, need be clearly defined within the stepped care model [7]. These should be based on decision tools that include pre-specified time intervals for conducting assessments and specific thresholds to guide patient outcome monitoring and when, and for whom, treatment should change [1, 2]. They should also incorporate knowledge of patient characteristics, adherence, and response to treatment to inform further treatment recommendations [2].

The use of standardised assessment instruments offers advantages in that they can be completed quickly and provide consistent outcome measures that can be used across organisations [7, 22]. Again, however, caution is required in basing assessment on a single criteria such as symptom severity, and should provide a role for clinical judgement and complexity assessment [7, 23]. Moreover, some studies found that while monitoring was sometimes useful to patients and professionals – giving focus and structure to consultations – scores were often not trusted and some patients were uncomfortable being monitored [2].

A recent review of stepped care interventions for depression showed that patient progress was measured using one (12 studies), two (1 study), or three (1 study) self-rated instruments [2]. Instruments varied and included: Center for Epidemiological Studies Depression Scale (CES-D); Clinical Global Impression Severity Scale (CGI-S); Coping With Depression (CWD); Hospital Anxiety and Depression Scale-Anxiety (HADS-A); Hamilton Depression Rating Scale (HDRS); and Work and Social Adjustment Scale (WSAS).

In some studies the decision to step-up was based on patients' scores relative to a specific cut-off on one of the above instruments. In others, the decision was dependent on improvement (relative to baseline or last assessment). Some studies used a combination of improvement and specific cut off [2].

The review showed considerable variance in the time intervals for monitoring. This depended, to some extent, on the different time intervals of the interventions featured in the studies that ranged from 6 weeks to 12 months. For a majority of studies, however, 6 to 8 weeks appeared to be the average for monitoring progress and for making decisions about stepping up or down patients [2].

2.6 Care co-ordination

Review finding: The current stepped care model is not consistent with the time-honoured concepts of continuity of care and integrated care. Consumers get lost in the system through poor communication, the 'dead-ends' of waiting lists, re-tracing of pathways to find the best-fit provider, and confusion caused by the different practices and cultures of service providers. GPs are not assured of formal feedback on referred patients once they leave the practice. Instead of being informed by formal written feedback, some GPs have patients themselves reporting back that they have had no treatment due to waiting lists or they have been directed to treatment of the wrong intensity.

Co-ordinating care to ensure collaboration and continuity in a system that includes multiple providers, points of entry, and patient mobility is a major challenge for stepped care. Poor integration and communication is a significant contributor to poor patient outcomes and the implementation of a fully functioning stepped care system [7]. If different steps are delivered by different providers or clinicians, then a liaison system

that streamlines processes for patients so that they are not burdened by multiple assessments and letters from different services is recommended [6].

Use of a single care plan is also recommended as the optimal means of establishing integrated care. This requires the development and implementation of information sharing systems between organisations, as well as establishing care pathways across providers [7]. Good working relationships, effective communication, and a secure platform for sharing information (together with appropriate consent processes) are important, yet these have been difficult to establish in extant service models [7].

Despite limited evidence, rates of stepping up in stepped care models appear generally low regardless of the assessment process, with one review of four UK sites showing no more than 10% of patients being stepped up to high intensity interventions. This was significantly lower in one site where there was a shortage of high intensity resources [6]. Stepping patients down was rare, even in sites with large numbers allocated to high intensity interventions [6]. According to the authors, this would require a high-intensity therapist to discuss lower intensity interventions during treatment, something that is unlikely once the therapist has engaged the patient.

One option for stepping down which is seldom discussed as a core component of stepped care but figures in models of optimal care are the principles of ongoing management and relapse prevention [6, 12]. This may take the form of lower levels of contact as described above, the use of internet or mobile-based interventions, or discharge to the management of a general practitioner.

To this end, enrolment with a primary care provider for those with complex problems should be encouraged as it is likely to improve care co-ordination and provide physical health treatment. Where this is required, bulk billing agreements with a core set of GPs would ideally be in place to ensure equitable access for all social groups.

Review finding: The central intake staff are very consumer-centred and carry out their roles with enthusiasm and commitment, but the role of central intake is not well-understood by referrers and service providers The central intake team could be more active in monitoring and quality and safety initiatives that guide and support GPs and service providers. This is related to the issue of an appropriate clinical governance role for PHNs in the primary mental health care system.

To successfully deliver integrated stepped care, systems that successfully manage the interface between steps, have formal procedures for monitoring progress and facilitating stepping up and stepping down, and have established mechanisms and protocols for sharing sensitive clinical and administrative information between organisations are needed [6, 7].

3 Commissioning and contracting

Review finding: Prior to contracting service, commissioning involves a process of co-design involving those who have direct experience of services (clinicians and consumers) and those who are responsible for building and sustaining the system (service purchasers). The co-design process appears not to have occurred in the development of the current service model. In future it will be important to involve the voice of experience including consumers, referrers, the central intake team and service providers in the design of subsequent models.

The role of integrated place-based planning in which commissioners and providers are engaged in a process of strategic planning, budgeting, and developing and agreeing outcomes is seen as increasingly important to the successful delivery of health services [24]. The case for local and integrated service responses is that they provide creative models for addressing major challenges that make best use of collective resources, knowledge and skills [24].

Hence, there needs to be clear mechanisms for local clinicians across primary, secondary and community care services, service users and carers to be involved in the process of planning and commissioning [25]. That is to say, co-design and collaborative planning processes should be established to create the basis for collective action [24, 26]. This should involve the development of a shared set of locally specific objectives that reflect existing challenges, as well as community and organisational needs, resources and capacity [24]. A collectively developed agenda helps to promote democratic decision-making, shared ownership and engagement in solutions [24, 26].

A strong strategic commissioning function must also ensure a continued focus on quality and improvement within local areas, and a reorientation of the local health care system toward the end user [27]. Commissioning and contracting provide important 'infrastructure', yet building trust in relationships between providers, commissioners and the public is also important.

In addition to processes for building effective collaboration between service providers, planning and commissioning should also involve the alignment of incentives with objectives, and mechanisms for holding organisations to account [24, 28]. As Ham and Alderwick write:

> Place-based systems are unlikely to be effective if they are merely a forum for discussion of issues of common concern without executive responsibilities. These and other issues need to be thought through at the outset to enable the right vehicles for collaboration to be established which are both binding and collective [24].

An emerging model of commissioning for health services reform is outcomes-based contracting (OBC). Rather than payment for service being determined by content,

activity or targets, OBC shifts greater responsibility onto service providers by having some payment dependent on achieving specific outcomes [29, 30]. Outcome measures can relate directly to clinical outcomes, explicit service user outcomes, or could be directed toward incentivising collaboration [29, 30]. These can also be weighted according to their ambition and overall value, and can be modified over the life of the contract to reflect longer term ambitions [30].

Agreeing upon outcome measures in collaboration with clinicians, service providers and service users is thought to be beneficial to ensuring longer-term buy-in to a new program, as well as communicating the scope and ambition of the program [30]. Focusing on outcomes can also increase transparency and accountability to funders and the public, and be used for organisational learning and improvement [31]. Implementing outcomes based approaches, however, requires considerable time, resources and commitment – as well as changes to culture and practices – to develop, negotiate, and operationalise performance indicators [30, 31]. Some common outcomes include:

- patient experience and satisfaction with services
- supporting people to manage their condition
- increasing patient involvement in decision-making
- improved patient outcomes
- delivery of co-ordinated and patient-centred care demonstrating joined-up working
- effective information sharing, including use of technology [32].

OBC can have adverse implications for health service systems. For example, it may involve additional administrative demands and greater organisational risk due to the unpredictability of future outcome payments [29]. Some OBC systems may favour large organisations who establish themselves as prime contractors, thereby reducing provider diversity and having a harmful effect on smaller organisations [29].

Differential payments linked to improved patient outcomes may also lead to providers offering services to patients who can be easily supported to achieve outcomes (‘creaming’), with patients with more complex issues or hard to reach populations neglected (‘parking’); thus undermining the principle of equality of access [29]. It may also disincentivise collaboration if only one service provider is paid for an outcome, or become grounds for power struggles in attributing certain outcomes to a provider in cases of integrated care [29].

Finally, research has found that the process of identifying outcome measures results in providers adapting practice to fit simple outcome measures, thereby overlooking more complex and nuanced activities such as engagement with carers and families [31]. Given these challenges, the linking of outcomes to financial reward may ultimately undermine the provision of public health services [31].

4 Capturing evidence to support improvement and transformation

Review finding: There is inconsistency between the current service contracts formats and limited specificity in areas such as formal clinical feedback to GPs, outcomes, assessment and service volumes. There is limited consumer feedback to the PHN on the current model. Some service providers and GPs have their own internal satisfaction surveys which they maintain diligently, and there are unspecified provisions in some contracts, but there appears to be no system-wide uniform approach.

The focus on outcomes remains an integral part of health services improvement and transformation. Outcomes based approaches are promoted to reform service design and delivery through a focus on efficiency, accountability, partnership, personalisation and co-production [31]. Focusing on outcomes can fulfil a range of purposes such as underlining what is important; judging and accounting for the effectiveness of local programs; and assisting learning and development [31].

Given the importance of outcome monitoring in stepped care to support clinical decision-making and to ensure interventions are responsive to patient need, the collection and analysis of routine data is imperative [4]. For those seeking to implement outcomes based approaches, evidencing the contribution of an intervention to outcomes using a range of indicators (qualitative and quantitative) and sources (individual, community, service, and population level) is a fundamental part of the improvement process [31].

Again, co-design and collaborative planning processes should be established to identify which specific outcomes should be measured, the measures to be used to capture outcome data, and the evaluation approaches for linking activity to outcomes [31]. While the alignment of local service and program priorities with local commissioning priorities will help build synergy, this will need to be balanced against the priorities of organisations that are driven by external standards or targets [28].

5 Workforce

Successful implementation of rural stepped care requires a multidisciplinary mental health workforce with workers trained in both low and high intensity interventions to meet population need across regional and rural areas. Workforce shortages in rural mental health care are well documented, and local population needs planning must inform the investments needed over the long term to fill them. This will include the establishment of clear workforce targets.

A common elements approach to stepped care (as discussed in 2.2) seeks to overcome shortages in local funding, personnel and infrastructure through the training

of para-professionals. Although more research is needed, evidence suggests that paraprofessionals are able to learn simplified common elements approaches through training and ongoing supervision [19]. Increased emphasis on identifying and training local peer support workers may also be warranted, especially in more remote communities and/or for engaging with hard to reach groups.

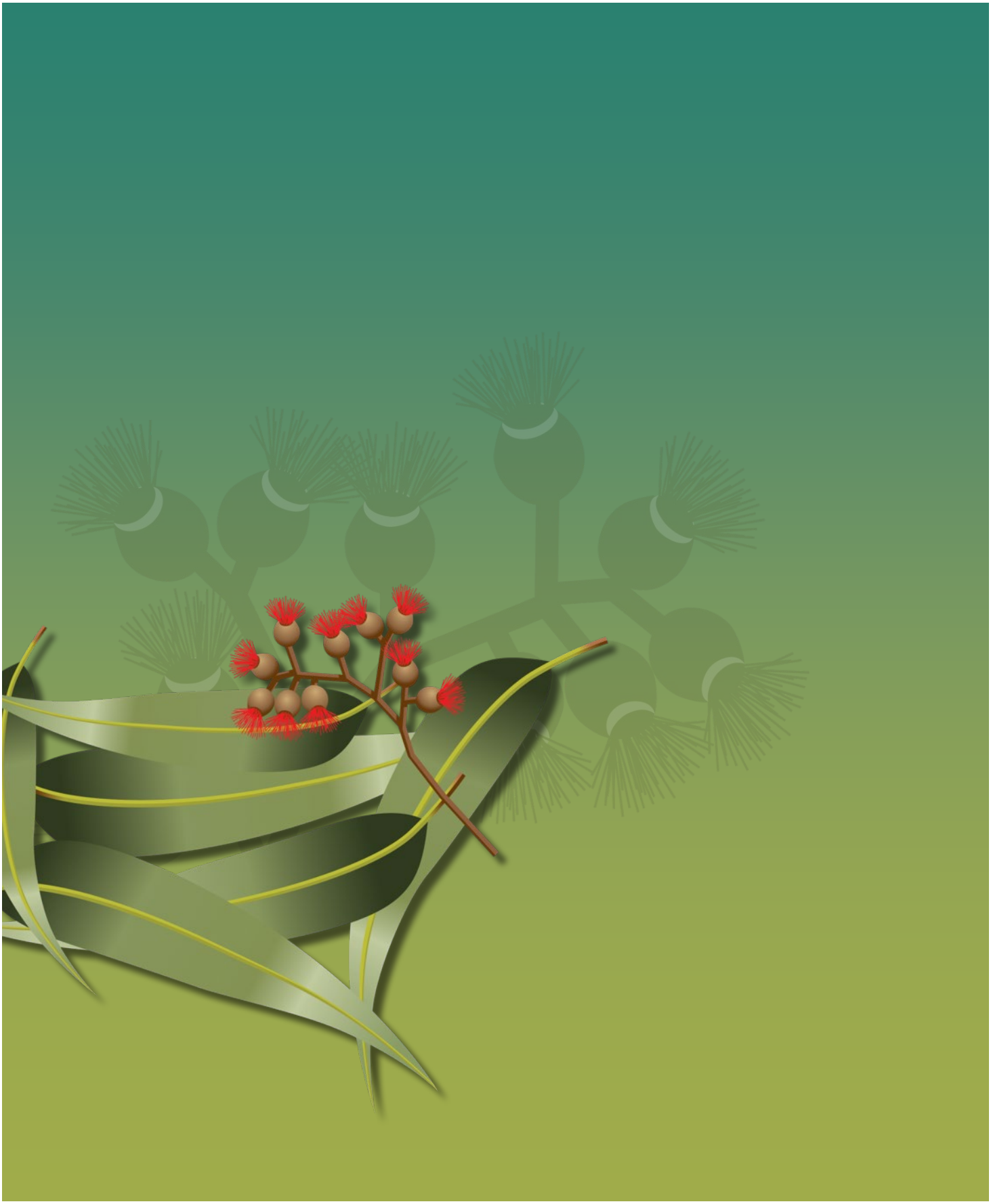
In the meantime, the PHNs' role is to identify local priorities and areas for investment to inform commissioning decisions and apportion to best effect the resources that are available now. If guided self-help for low intensity care is to be more fully utilised, both GPs and the general population will need to be fully informed about these new low intensity pathways [6, 7].

6 References

1. O'Donohue, W.T. and C. Draper, The case for evidence-based stepped care as part of a reformed delivery system. In *Stepped care and e-health: Practical applications to behavioural disorders*, eds. W.T. O'Donohue and C. Draper. Springer: New York, 2011; p. 1-16; 2011.
2. Hill, J.J., *Stepped Care for depression: A systematic review and feasibility study*. Unpublished PhD thesis, Faculty of Psychology. 2016, University of Exeter: Exeter, UK.
3. Bower, P. and S. Gilbody, Stepped care in psychological therapies: Access, effectiveness and efficiency: narrative literature review. *The British Journal of Psychiatry*, 2005. 186(1): p. 11-17.
4. Richards, D.A., et al., Delivering stepped care: an analysis of implementation in routine practice. *Implementation Science*, 2012. 7(1): p. 3.
5. Coyle, D. and G. Doherty, Stepped care and mental health technologies. *ECCE 2010 workshop on Cognitive Engineering for Technology in Mental Health Care and Rehabilitation*. 2010: Delft, The Netherlands.
6. Richards, D.A., et al., D*eveloping evidence-based and acceptable stepped care systems in mental health care: An operational research project*. Final Report, NIHR Service Delivery and Organisation Programme, 2010.
7. Leitch, E., et al., I*mplementing a stepped care approach to mental health services within Australian primary health networks: Report to the Department of Health*. 2016, University of QLD: Brisbane. Retrieved from: https://qcmhr.uq.edu.au/wp-content/uploads/2017/02/Stepped-Care-Report-UQ-20170220.pdf
8. Meurk, C., et al., Systems levers for commissioning primary mental healthcare: a rapid review. *Australian Journal of Primary Health*, 2018. 24(1): p. 29-53.
9. Williams, C. and R. Martinez, Increasing access to CBT: stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy*, 2008. 36(6): p. 675-683.

10. Bower, P., et al., Influence of initial severity of depression on effectiveness of low intensity interventions: meta-analysis of individual patient data. *British Medical Journal*, 2013. 346.
11. National Collaborating Centre for Mental Health, Depression: *The NICE guideline on the treatment and management of depression in adults. Updated edition. Clinical guideline 90.* 2010, The British Psychological Society and The Royal College of Psychiatrists: London.
12. Hermens, M.L., et al., Stepped care for depression is easy to recommend, but harder to implement: Results of an explorative study within primary care in the Netherlands. *BMC Family Practice*, 2014. 15(1): p. 5.
13. Cross, S. and I. Hickie, Transdiagnostic stepped care in mental health. *Public Health Research and Practice*, 2017. 27(2): p. 1-4.
14. National Institute for Health and Care Excellence, *NICE commisioning guides [CMG41]: Commissioning stepped care for people with common mental health disorders*. 2011.
15. Fanner, D. and C. Urquhart, Bibliotherapy for mental health service users Part 1: a systematic review. *Health Information & Libraries Journal*, 2008. 25(4): p. 237-252.
16. Gellatly, J., et al., What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychological Medicine*, 2007. 37(09): p. 1217-1228.
17. Bendelin, N., et al., Experiences of guided Internet-based cognitive-behavioural treatment for depression: A qualitative study. *BMC Psychiatry*, 2011. 11(1): p. 107.
18. Frude, N. *Book prescription Wales 2011 A strategy for enhancing treatment choice for mental health: Prescriber information booklet.* 2011. Retrieved from: http://www.wales.nhs.uk/sitesplus/documents/829/BPW%20Prescriber%20Information%20booklet%20.pdf
19. Murray, L. and M. Jordans, Rethinking the service delivery system of psychological interventions in low and middle income countries. *BMC Psychiatry*, 2016. 16(1): p. 234.
20. Chorpita, B.F., E.L. Daleiden, and J.R. Weisz, Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, 2005. 7(1): p. 5-20.
21. Australian Government Department of Health, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance - Stepped Care*. Australian Government Department of Health: Canberra. Retrieved from: http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF
22. van Straten, A., et al., Stepped care for depression in primary care: what should be offered and how? *Medical Journal of Australia*, 2010. 192(11): p. S36.

23. Schaink, A.K., et al., A Scoping Review and Thematic Classification of Patient Complexity: Offering a Unifying Framework. *Journal of Comorbidity*, 2012. 2(1): p. 1-9.
24. Ham, C. and H. Alderwick, *Place-based systems of care*. 2015, The Kings Fund: London.
25. Public Consulting Group. *Strategic commissioning*. 2018; Available from: https://commissioning.connecttosupport.org/s4s/WhereILive/Council?pageId=1764.
26. Gudes, O., et al., Rethinking health planning: a framework for organising information to underpin collaborative health planning. H*ealth Information Management Journal*, 2010. 39(2): p. 18-29.
27. NHS Clinical Commissioners, *Making strategic commissioning work: Lesson from home and away*. 2017: London. Retrieved from: https://www.nhscc.org/policy-briefing/strategic-comm-home-away/
28. Australian Social Inclusion Board, *Governance models for location based initiatives*. 2011, Department of Prime Minister and Cabinet: Canberra. Retrieved from: http://www.culturemap.org.au/sites/all/files/Governancemodelsforlocations.pdf
29. Farr, M., Co-production and value co-creation in outcome-based contracting in public services. *Public Management Review*, 2016. 18(5): p. 654-672.
30. Price Waterhouse Coopers The King's Fund and The University of Melbourne, *Challenges and lessons for good practice*. 2016, Australian Government Department of Health: Canberra. Retrieved from: http://www.health.gov.au/internet/main/publishing.nsf/Content/0DA0E153E02C0501CA2582E900023FD0/$File/Literature%20and%20evidence%20review%20v0.1.pdf
31. Cook, A., *Outcomes Based Approaches in Public Service Reform*. *What Works, 2017*. Retrieved from: http://whatworksscotland.ac.uk/wp-content/uploads/2017/04/OutcomeBasedApproachesinPublicServiceReform.pdf
32. Addicott, R., *Commissioning and contracting for integrated care*. 2014, London: The King's Fund.



Centre for Rural and Remote Mental Health
T: +61 2 6363 8444 **E:** crrmh@newcastle.edu.au
PO Box 8043 Orange East NSW 2800
Website Facebook Twitter YouTube

Centre for Rural & Remote Mental Health

THE UNIVERSITY OF NEWCASTLE AUSTRALIA